

10 Chronic Care / Mental Health

Non-communicable diseases (NCDs) are increasingly being recognised as a major contributor to preventable disease and premature mortality in low and middle-income countries.¹ Although widely acknowledged as a major cause of preventable morbidity and mortality in high-income countries, data have now shown that NCDs are increasingly and disproportionately affecting low-income countries.² Furthermore, NCD-attributable deaths are projected to increase by 15% globally between 2010 and 2020, with the highest increase expected to occur in Africa (over 20%).² In South Africa the first National Burden of Disease study revealed that NCDs accounted for the highest proportion (37%) of deaths nationally.³ This is primarily due to an increase in the ageing population and changes in distribution of risk factors linked with NCDs.⁴ Outcome 2 of South Africa's Negotiated Service Delivery Agreement (NSDA) for health indicated that health promotion and early detection of NCDs would be introduced. It further stated that this would occur through a number of ways including active case-finding and routine screening for NCDs, particularly in PHC facilities.⁵ Inclusion of screening of NCDs as part of the HIV Counselling and Testing (HCT) campaign indicates commitment to this undertaking. The NSDA also recommended the strengthening of monitoring and evaluation systems within primary health care (PHC) facilities as a means to facilitate management of NCDs.

In September 2011 a high-level meeting on prevention and control of NCDs was convened by the United Nations Global Assembly. This event was intended to highlight the global NCD crisis and the threat NCDs pose to the achievement of developmental goals, particularly in developing countries.⁶ One of the key points was the call to member states to develop a comprehensive monitoring framework, including a set of indicators to assess progress in plans to combat NCDs.⁶

NCDs are chronic medical conditions. They include cardiovascular disease (stroke and heart disease), cancers, type 2 diabetes, chronic respiratory diseases (such as asthma and chronic obstructive airways disease) and mental health disorders.⁷ Some NCDs are often associated with modifiable risk factors such as hypertension, smoking, obesity, physical inactivity and raised cholesterol.⁸ The primary focus of this chapter, however, will be on hypertension and mental health.

Hypertension is a leading NCD risk factor globally, accounting for 13% of global deaths.⁹ The prevalence of hypertension was also estimated to be highest in the WHO African region at 46% compared to 35% for the Americas region.² The high prevalence of hypertension in South Africa has been documented in a number of studies with estimates ranging from 14% to 33% reported.^{7,9,10,11}

Mental health disorders, such as depression, alcohol disorders and psychoses, are among the 20 leading causes of disability worldwide, with unipolar depression being the third leading contributor to burden of disease.¹² The South African Stress and Health survey, the first large-scale population-based study of common mental health disorders in South Africa, estimated that approximately 16.5% of South Africans reported suffering from a common mental disorder.^{12,13}

Mental health disorders are often associated with other NCDs, HIV, tuberculosis and injuries.⁷ In addition, many of these health disorders (e.g. HIV) increase the risk of mental illness.¹² This highlights the importance of understanding and documenting the large mental health burden in this country. However, inadequate population-level morbidity data hinders effective planning and decision making with regard to mental health healthcare services.¹²

Although there may be variations in data quality and consistency in these chronic care indicators, they may still prove useful. These indicators do not give a direct indication of the burden of disease in the various districts, but rather a proxy of the burden of NCDs on PHC facilities that may be useful for planning and decision making for chronic care service delivery.

10.1 Hypertension detection rate

The hypertension detection rate is defined as newly diagnosed hypertension patients put on treatment (numerator) as a proportion of the PHC headcount 5 years or older (denominator).

The average hypertension detection rate for the country was 0.25%, as shown in Figure 1; slightly down from 2010/11 (0.32%) and 2009/10 (0.27%). Figure 1 also shows that over a third of the districts had hypertension detection rates above the national average, with John Taolo Gaetswe (NC) (0.41%) and Gert Sibande (MP) (0.38%) ranked first and second respectively and Capricorn (LP) ranked last (0.11%).

Figure 2 shows that annual trends in hypertension detection rates have been relatively stable in all provinces since 2007/08 with the exception of Eastern Cape and North West where Alfred Nzo and OR Tambo (both EC) showed spikes in 2010/11 and Ngaka Modiri Molema (NW) showed a spike in 2009/10.

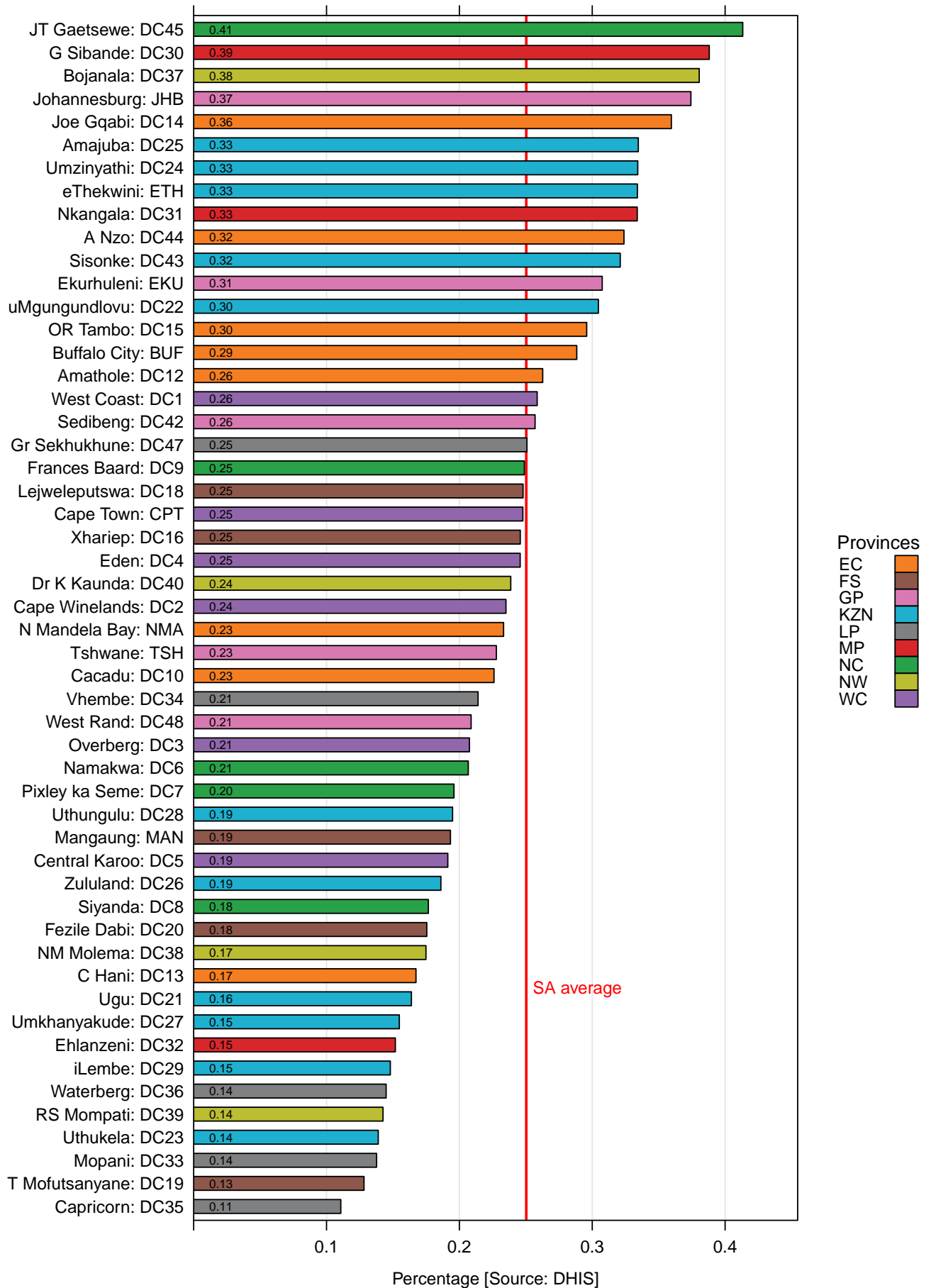
Figure 3 shows a significant increase in total number of newly diagnosed hypertensive patients put on treatment in the 2010/11 and 2011/12 financial years in eThekweni (KZN) and Johannesburg (GP). This, however, did not result in a concomitant increase in hypertension detection as the total PHC headcount (denominator) over this time also increased. As illustrated in Figure 3, there was a steady increase over time in the total number of newly diagnosed hypertension cases

Section A: Indicator Comparisons per programme by District

initiated on treatment within Cape Town Metro (WC) between 2006/07 and 2011/12. However, the total PHC headcount 5 years and over also increased steadily over time for this district. Thus, the hypertension detection rates for the district have remained steady over time.

Figure 4 depicts the hypertension detection rates (box-and-whisker plots) by socio-economic quintiles (SEQ). Although there are some notable outliers in SEQ 1 and 2 in 2009/10 and 2010/11, there does not appear to be a significant pattern in rates by SEQ over the years.

Figure 1: Hypertension detection rate, by district, 2011/12



Section A: Indicator Comparisons per programme by District

Figure 2: Annual trends: Hypertension detection rate

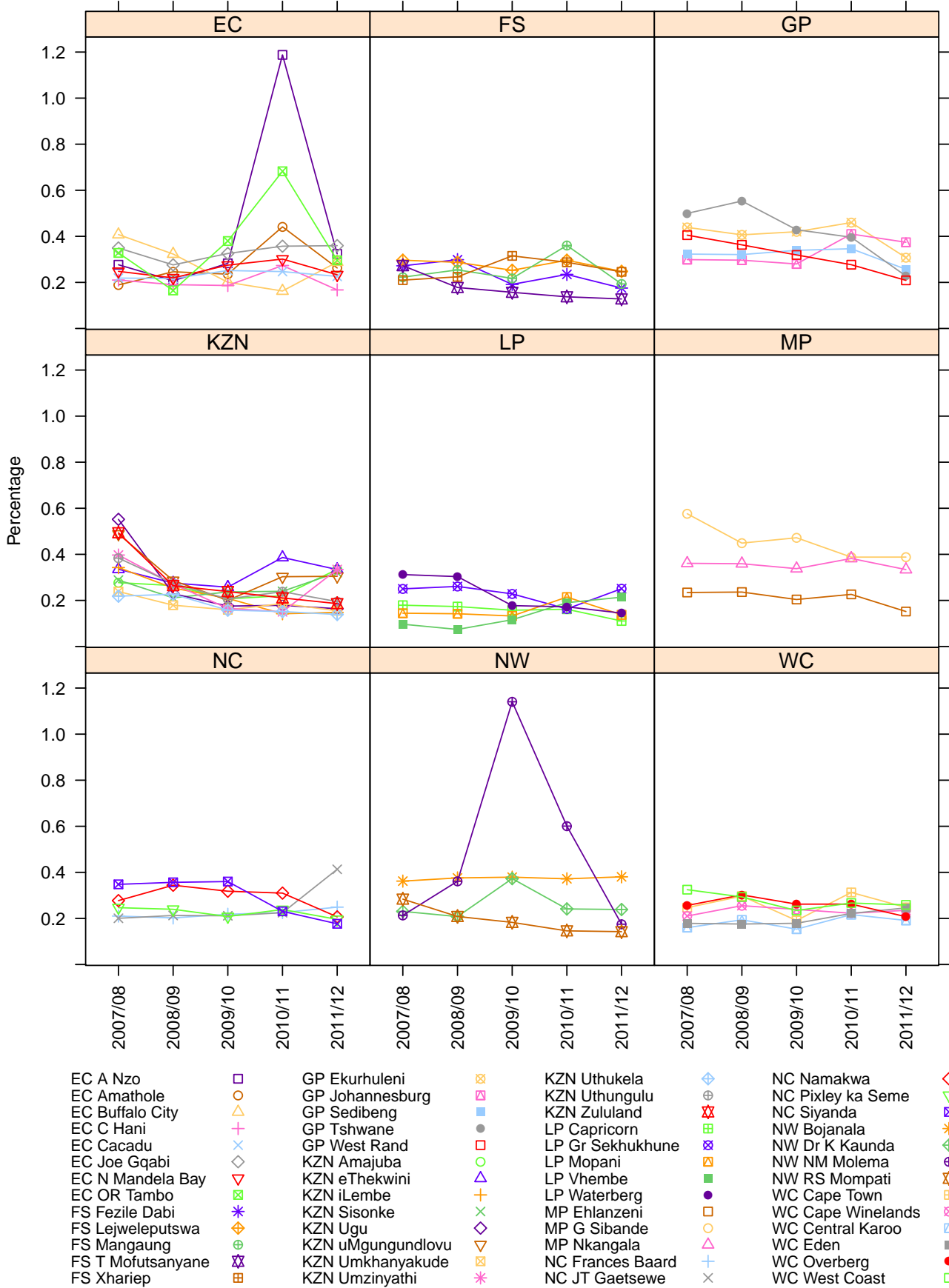


Figure 3: Hypertension detection rate – numerator

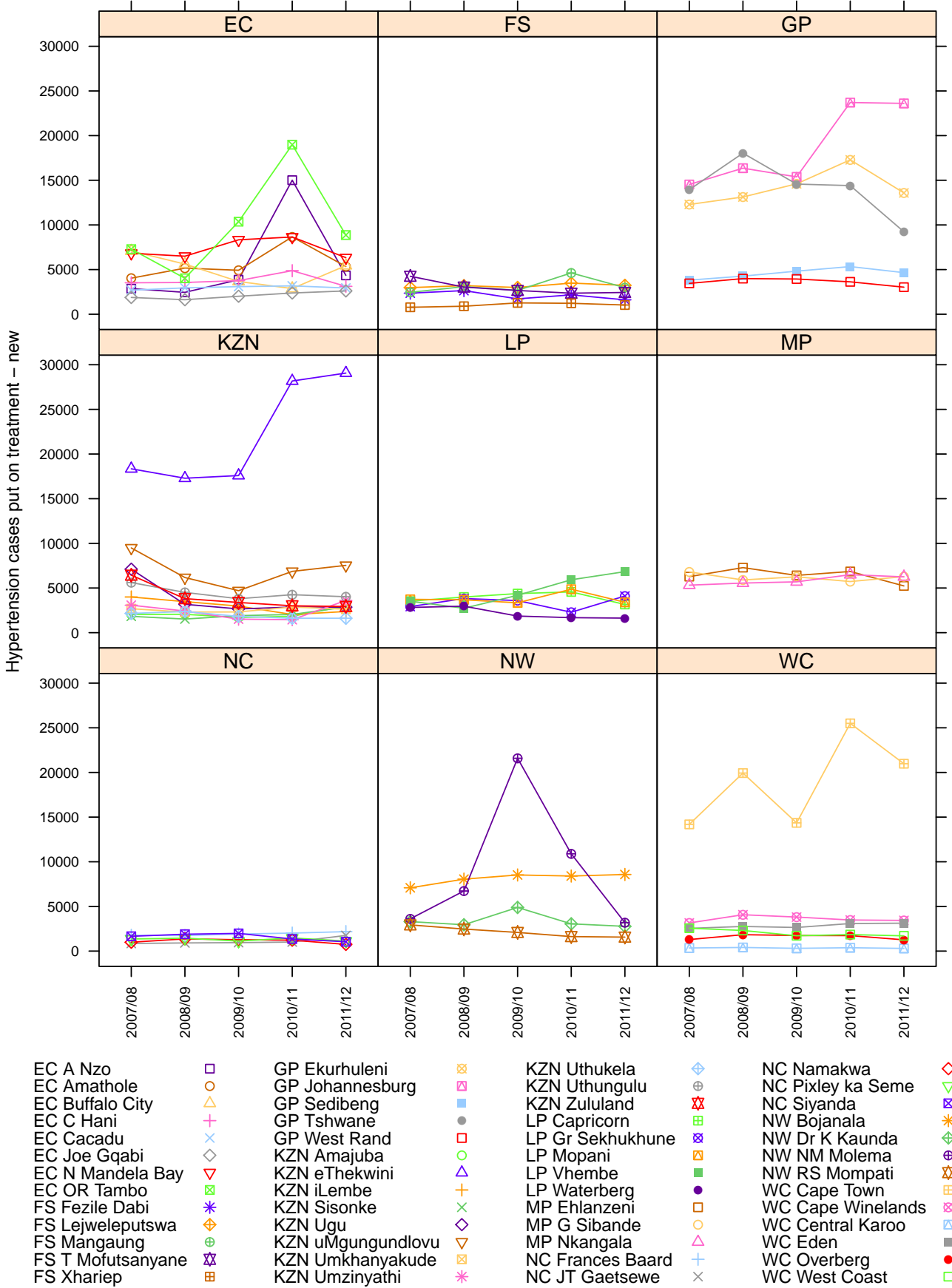
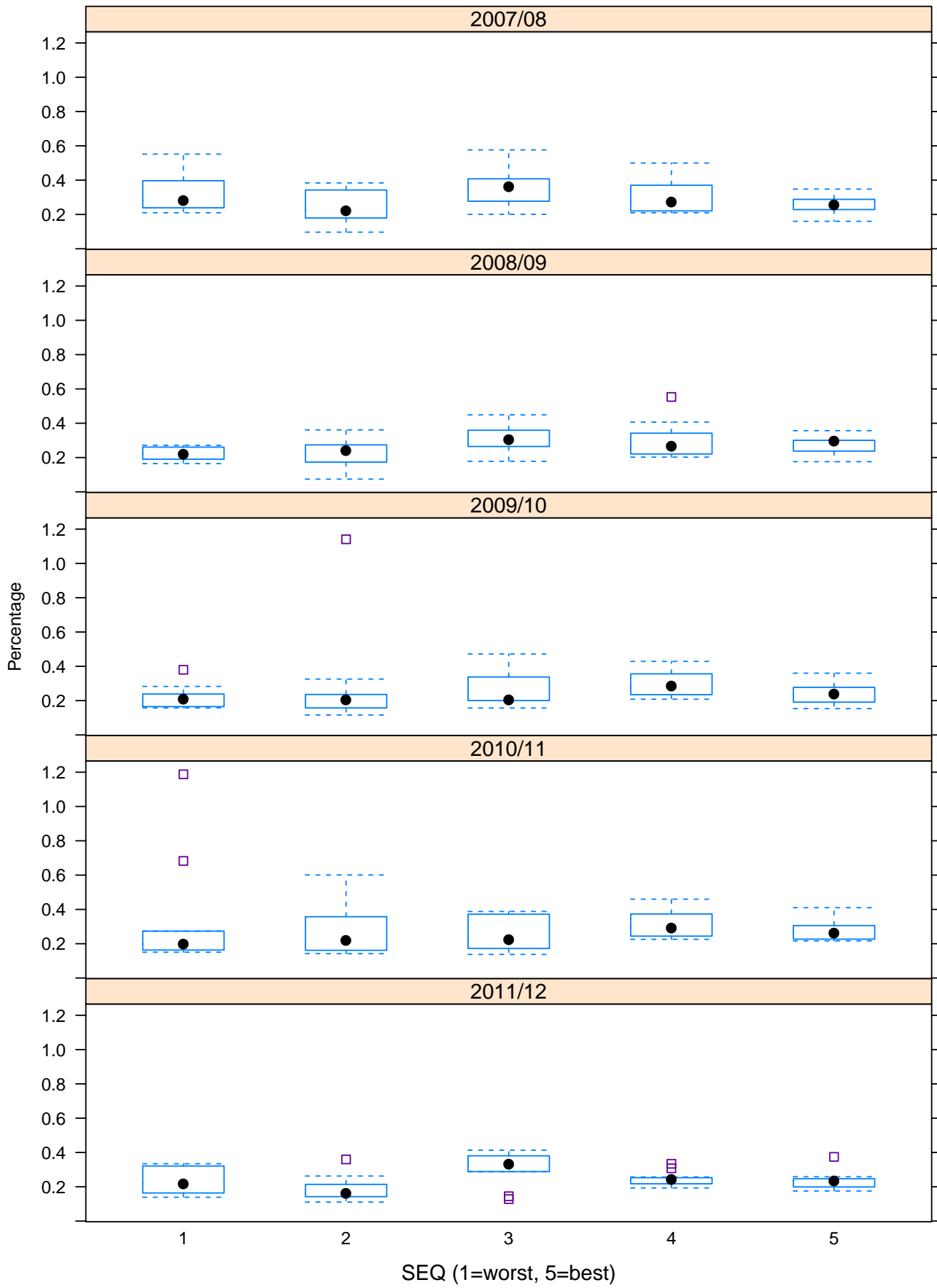


Figure 4: Hypertension detection rates by socio-economic quintiles (SEQ), 2007/08 - 2011/12



10.2 Mental health case load

The mental health case load is defined as the number of mental health visits as a percentage of PHC total headcount.

Figure 5 shows that 21 out of 52 districts had mental health case loads above the national average of 1.4%. Central Karoo (WC) and Nkangala (MP) had the highest mental health case loads at almost twice the national average, 2.8% and 2.6% respectively. Nelson Mandela Bay metro (EC) had the lowest mental health case load at only 0.1%.

Figure 6, which displays the mental health case load (box-and-whisker) plots by province, shows significant variation in range by province – particularly in Eastern Cape, KwaZulu-Natal, Mpumalanga and Western Cape. This may indicate inconsistency in collection of data pertaining to mental health cases.

There appears to be a slight increase in average mental health case load with increasing SEQ as depicted in Figure 7. However, there are significant outliers in SEQs 3 and 5 which may skew this apparent pattern making it difficult to determine if this increase is due to better access to services.

Map 1 does not appear to demonstrate any specific pattern in distribution of mental health case load. Six out of 52 districts are shown to have mental health case loads above 2%, which may be due to poor data quality.

Figure 5: Mental health case load by district, 2011/12

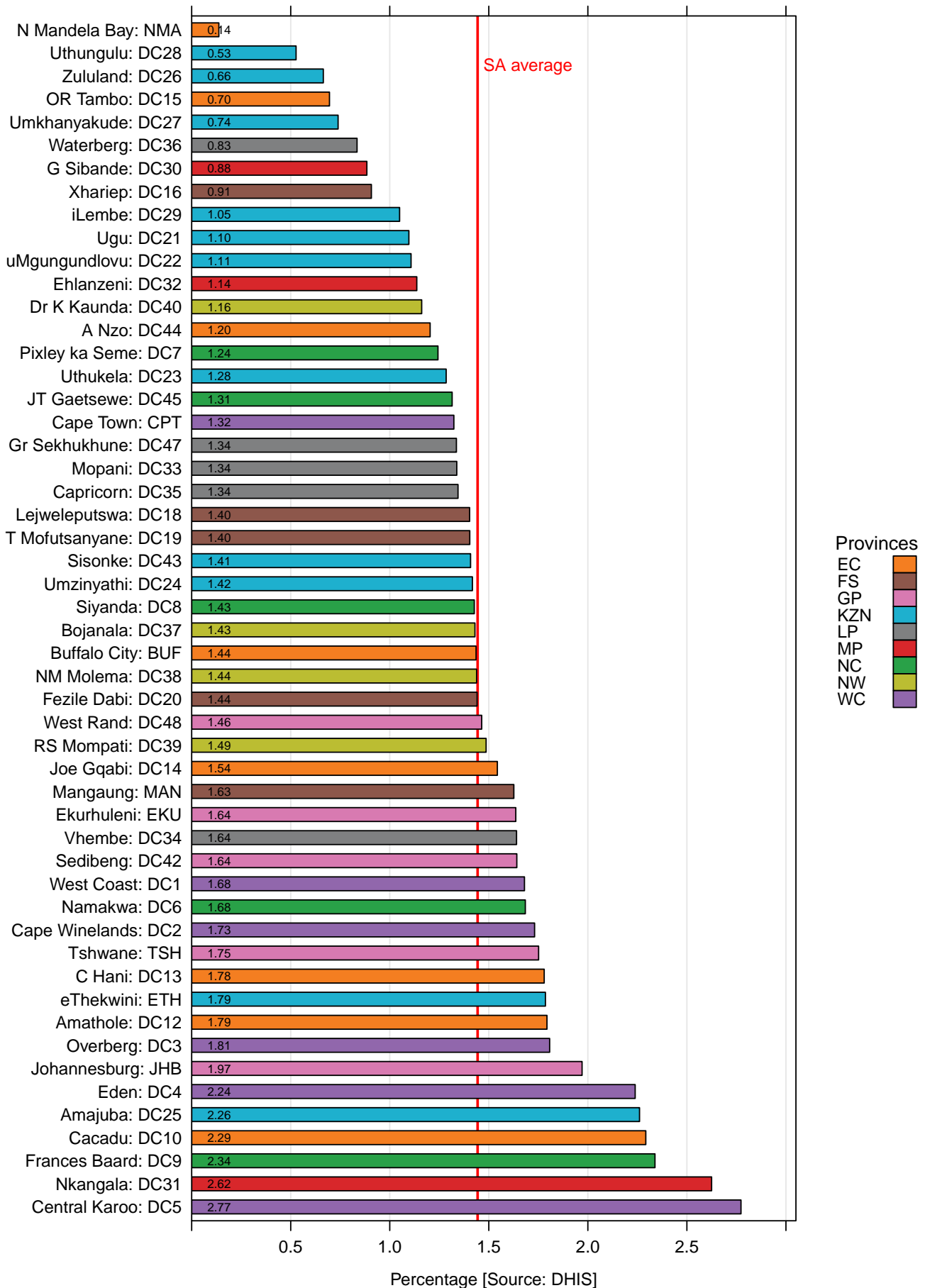


Figure 6: Box-and-whisker plot by province: Mental health case load, 2011/12

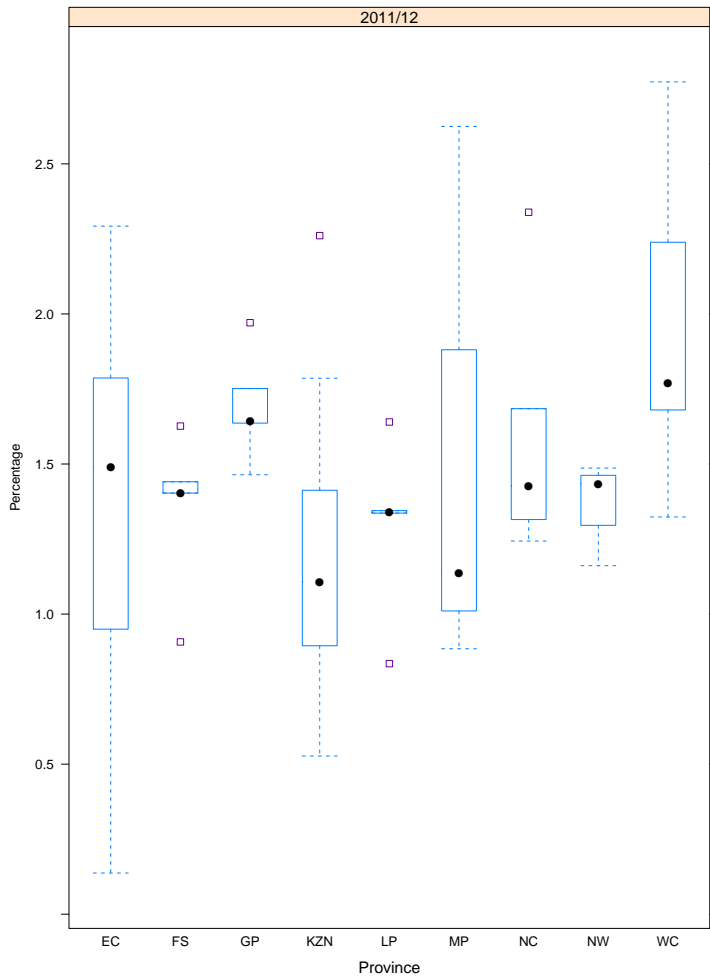
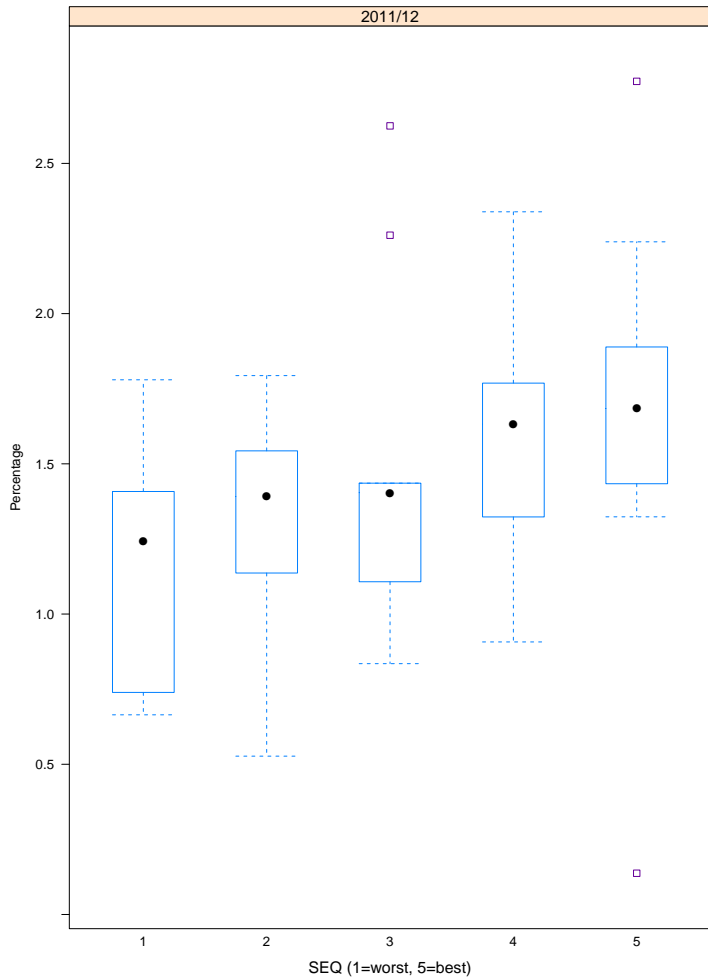
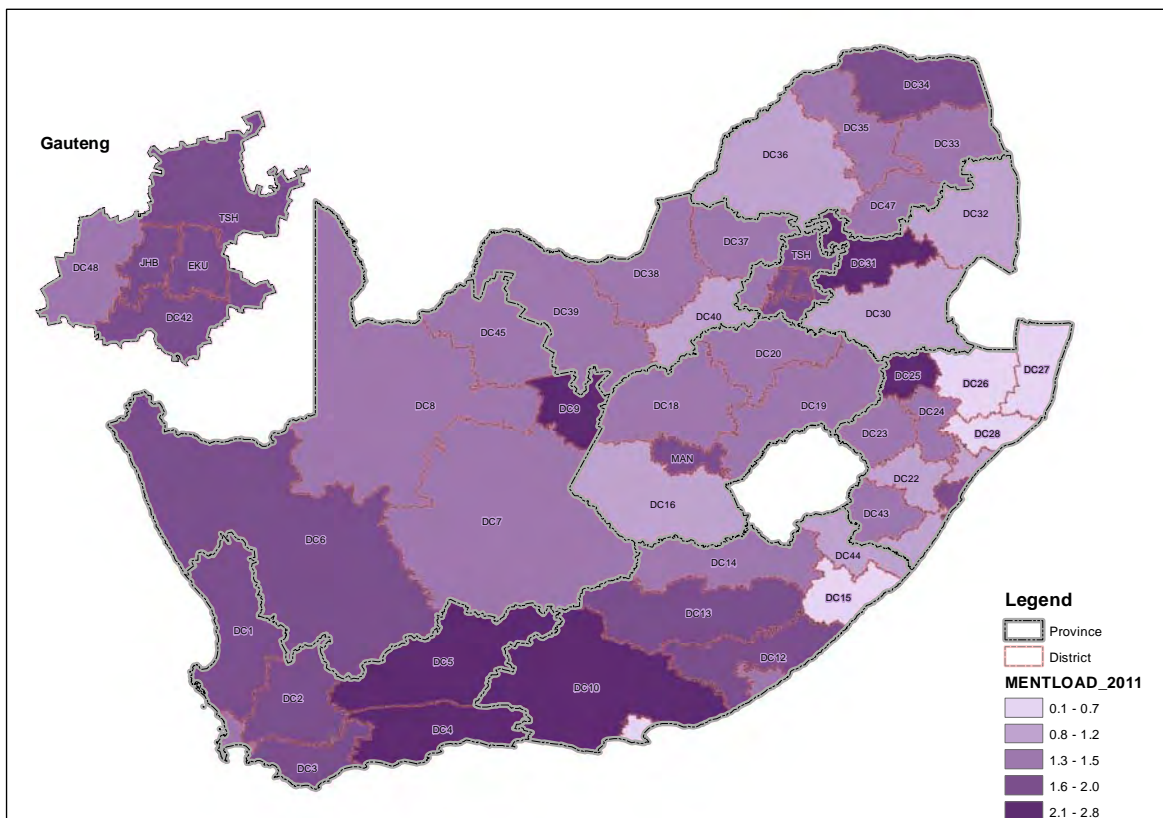


Figure 7: Box-and-whisker plot by socio-economic quintile: Mental health case load, 2011/12



Map 1: Mental health case load by district, 2011/12



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